9. After the return of the patient to bed, if the condition of the stomach will permit, a ten-grain dose of calomel is given. If chloroform has been used, this will generally be retained. Rectal stimulation is used for the first twenty-four hours.

OTOLOGY.

UNDER THE CHARGE OF

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Elephantiasis of the Auricle.—HAUG reports the occurrence of elephantiasis of the right auricle in a girl aged twenty years. Ten years previous to the time Haug first saw the case the girl had had whooping-cough, during which hemorrhages from the left ear and extravasation of blood beneath the integument of the auricle took place. The long diameter of the enlarged auricle, measured from the spina helicis to the lobule, amounted to 12½ cm., and the transverse diameter, from the outer edge of the helix to the antitragus, to 7 cm. The breadth of the lobule amounted to 4½ cm.

Microscopic examination of a small piece revealed that the enlargement of the tissues consisted in a lymphangio-fibroma with hyperplasia of the cartilage and the perichondrium.—*Archiv f. Ohrenheilk.*, vol. xliii., Part I.

Myxo-cysto-fibroma of the Cartilaginous Auditory Canal.—HAUG also reports the occurrence of the above-named growth in the auditory canal of a man, aged thirty-eight years (*Archiv f. Ohrenheilk.*, vol. xliii., Part I.). The growth had been increasing in size for four years, had not been preceded by discharge, and had finally attained the size of a cherry. Within six months a slight, fetid discharge had set in, but the hearing had not been much affected.

The entire growth was removed with a cold wire snare. This was not followed by much hemorrhage. The tumor measured 2½ cm. in length. The membrana tympani was found to be intact and the hearing good.

Removal of Foreign Bodies from the Ear.—HUMMEL makes the following deductions respecting the relation sustained by the external auditory canal to foreign bodies in it, and gives some rules for the removal of such obstructions from the ear:

1. The relation of the normal ear-canal to inanimate foreign bodies is entirely without reaction—*i. e.*, the foreign body in the ear does not, *per se*, endanger the integrity of the ear.

2. Every hasty endeavor at removal, therefore, is not only unnecessary, but can become very injurious.

3. In all cases not previously interfered with (with very few exceptions), the foreign substance can be removed from the ear by means of syringing.

4. The general practitioner should never employ anything but the syringe, in his endeavors at removal of foreign bodies from the external auditory canal.

5. An instrumental removal of a foreign body from the ear sould be effected only by one fully able to examine the ear with an otoscope and acquainted with every operative manipulation in this region.—*Münchener med. Wochenschrift*, No. 17, 1897.

Acute Otitis Media in Infants.—Acute otitis media in infants is often confounded with cerebral disease, and hence escapes proper attention and treatment. In alluding to this form of disease, SIR WILLIAM DALBY (*British Medical Journal*, July 24, 1897) points out that in the case of infants the constitutional symptoms and demeanor of the little patient as indicating pain of an acute and agonizing character, or pain prolonged over many days, are the sole evidences within our hands of ear disease. The heightened temperature alone is not sufficient guide as to the necessity of paracentesis, and sometimes inspection of the drum-membrane will not show this necessity. "In a large proportion of cases leeches and hot fomentations will cut short inflammations of the tympanic cavity, but it would be safe to adopt the rule that when they do not (for if they relieve, they do so at once), a vertical incision should be made in the posterior section of the membrane." The incision does no harm, Dalby says, even if no pus is found pent up in the drum-cavity. Again, "in the infantile forms of this inflammation (not connected with the exanthemata), the process is often slow, subacute, the case dragging on day after day without the membrane giving way."

[These delays are dangerous, as a week's delay in rupture of the drum may lead to damming back of the pus, through the posterior wall of the drum-cavity, into the cerebellum, with fatal termination, as in a child of six years observed by your reporter.]

J. H. MARSH (*British Medical Journal*, July 24, 1897), in writing of this same important subject, thus tabulates the symptoms which should suggest the ear as the cause of the illnesses often attributed to other sources: 1. The child constantly endeavors to rub the affected ear. 2. It utters a sharp cry of pain on pressure being made below the meatus. 3. It refuses to rest its head on the affected side.

The same author states that "the clinical signs which would suggest that the lesion had a tuberculous origin are: 1. A slow non-sthenic onset. 2. Early glandular enlargement. 3. Early facial paralysis. 4. Resistance to the ordinary measures of treatment. 5. The presence of other tubercular disease. These cases require the establishment of a free opening into the middle ear through the mastoid."

[This last-named procedure *should not* precede removal of the carious and necrotic ossicula. The latter operation will generally check the suppuration and do away with all necessity for opening the mastoid. If the mastoid is opened in such cases, and the carious ossicula are left in place, as I have seen done, suppuration with all its attendant risks of deeper lesions will continue, to stop only after a removal of the carious ossicula.]

E. PONFICK (*Berlin. klin. Wochenschrift.* September 20, 1897) points out that in children under four years of age great confusion in diagnosis often arises